

EXHIBIT 13

CAPOOR PEDIATRIC NEUROMUSCULAR REHABILITATION, P.C.

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Pediatric Neuromuscular Assessment

Name: A.S.
DOB:

In preparation of this report, I reviewed the medical and school records of A.S., the deposition testimony of A.S.'s treating physicians and the deposition testimony of Marthee Sansone. History was also obtained during phone conversation with A.S.'s mother Marthee Sansone on August 12, 2017. In addition to the above, I rely on my education, training and experience in arriving at the opinions set forth below.

Chief Complaint: A 12-year-old male with metopic synostosis secondary to valproate acid syndrome.

Birth and Past Medical History: A.S. was born full-term via induced NSVD at Anderson Hospital in Maryville, Illinois to a 30-year-old female with one previous pregnancy. Birth weight was 5 pounds 14 ounces. Mother took Depakote for adult-onset epilepsy beginning approximately five years prior to pregnancy and she had two seizures during her pregnancy with A.S.. His mother also took Synthroid during pregnancy. A.S. was diagnosed with congenital metopic craniosynostosis and microcephaly at birth and discharged from the newborn nursery after two days.

April 2005 skull x-ray at St. John's Mercy Hospital was read as hypertelorism with possible metopic synostosis. May 2005 CAT scan with 3D surface reconstruction showed unremarkable brain structure and marked metopic synostosis. A.S. was evaluated by a neurologist and a neurosurgeon at St. Louis Hospital in July 2005. Due to progressively worsening metopic synostosis with cosmetic impairments, A.S. underwent surgical correction with cranial vault re-contouring with bilateral frontotemporal and supraorbital reconstruction by plastic surgery and neurosurgery in August 2005.

A.S. was followed annually by the cleft palate and interdisciplinary craniofacial team at St. John's Mercy Hospital from age 4 months to age 9 years old. His craniofacial team includes multiple specialties including: otolaryngology, neurosurgery, neurology, plastics, dental, speech therapy, audiology and child psychology. He is also followed by eye doctor at the Litchfield Walmart.

Course by Systems:

With his cognitive limitations, **A.S.** will not be able to make high level financial, medical and legal decisions. He will require guardianship. He will require safety supervision for daily living activities. He may need monitoring by neuropsychologist, and episodic OT and ST as an adult to meet new challenges, new demands, and maximize his potential with new technologies to improve his independence.

Neuromotor control and musculoskeletal issues: Children with autism and ADHD have impaired balance, impaired gross motor and fine motor control, impaired coordination and manipulation, impaired motor planning, impaired posture and body awareness, and impaired sensory processing skills. These problems limit independence in community mobility and self-care skills including dressing, feeding with utensils, bathing, grooming, hygiene, acceptance of activities of daily care, acquisition of skills for activities of daily living, exploration, play participation, and social participation. **A.S.**'s reported motor coordination issues, in combination with his cognitive impairment, communication, social, behavioral, and multi-sensory deficits including auditory, olfactory and tactile sensory disturbances, not only limit his ability to impact his ability to access and safely navigate his environment, but also limit his ability to problem solve around his motor difficulties, and request assistance for daily activities. **A.S.** may benefit from episodic PT/OT to improve his postural control, motor planning and coordination skills.

A.S. may require with specialty care with developmental and behavioral pediatricians, psychiatrists, neuropsychologists, neurologists, otolaryngologists, plastic surgeons, and neurosurgeons for treatment of his metopic stenosis and its secondary complications.

Recommendations: **A.S.** will require ongoing special education services and multidisciplinary therapy services, including OT, ST, PT, as well as psychosocial and behavioral therapy with family-oriented strategies that encourage acquisition and extension of basic developmental skills and language exposure. Adaptive self-care skills exhibited by children with neuro-cognitive delays are critical in determining the support that will be required in the home, school and community environment. Low IQ is associated with behaviors which can lead to self-injury, caretaker injury, property damage, isolation from family, peers and community and placement in a more restrictive setting. **A.S.** will require environmental adaptations and use of assistive technology to make best use of his impaired cognitive and motor skills. Direct instruction and environmental supports, such as prompts and simplified routines, as well as care by an attendant are necessary for **A.S.** to ensure that deficits in self-care skills, such as dressing, feeding and hygiene, and decreased opportunity for socialization and participation do not come to limit quality of life and safety.

Recent literature supports that the developing brain may be more vulnerable to and show less recovery of neurocognitive and functional skills from brain injury. The permanence of **A.S.**'s cognitive, communication, neuromotor and sensory deficits with physical disabilities may preclude him from meaningful employment.

Although progress may be made with growth, development and participation in therapies and school, **A.S.** will have developmental delays for the remainder of his life. He will require a

legal guardian for medical, financial and legal decision making. He may never be able to live independently and may require attendant care or placement into a facility.

Summary: In summary, **A.S.** has cognitive, communication, physical, behavioral, social, and sensory deficits and delays. He is restricted from employment choices and will require safety supervision during daily routine, for appropriate nutrition, for effective communication, for socialization, for transportation, for prevention and identification/treatment of medical complications, and for medical/legal/financial decisions. **A.S.** will not be able to live independently.

Without continuous direct supervision with assistance, **A.S.** is at risk for delayed interventions for otherwise avoidable medical complications and injuries that result in emotional suffering and disability, additional medical crisis interventions, avoidable testing and extra hospitalizations.

A.S. has permanent disabilities requiring continuous care, monitoring, supervision, and access to services with preventative care, in order to maximize his quality of life, as well as prevent injuries and secondary medical complications.

A.S. has and will continue to experience distress, anxiety and suffering related to metopic stenosis and its secondary complications. In the future, he may require additional painful medical procedures and treatments that may require hospitalization and separation from his family.

Based upon my review of the records, evaluation of **A.S.**, and experience in the evaluation and treatment of patients with his spectrum of physical, cognitive and developmental disabilities, it is my further opinion that with proper supervision and support, and access to consistent and appropriate medical and rehabilitative care, equipment and services, **A.S.** should live to a normal life expectancy.

These findings, conclusions, assessment and recommendations represent my opinions within a reasonable degree of medical certainty, based on my own evaluation of **A.S.**, my review of the medical, legal, and educational records, based on my college and medical school education, based on my postgraduate training in Physical Medicine and Rehabilitation, and quadruple board certification in Pediatric Physical Medicine and Rehabilitation, General Rehabilitation Medicine, Sports Medicine and Spinal Cord Injury Medicine, based on my 14 years of post-residency practice in the field of Pediatric Physical Medicine and Rehabilitation, including my experience as Chief of Rehabilitation Medicine at Blythedale Children's Hospital until 2012, and based on my ongoing continuing medical education.

My most recent curriculum vitae is attached for a full background of my professional experience. These opinions are provided with consideration of data available at the time of this report, as additional new data becomes available, I reserve the right to update, amend, and revise the reported findings, conclusions and opinions.